BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
EUGENIO LIMBAGO BAQUIAL	CASE No. 2012-345
	OAH No. 2012020985
Registered Nurse License No. 722918	
Respondent.	

NOTICE OF DECISION AND ORDER

No action having been taken on the attached Proposed Decision, pursuant to Government Code section 11517(c)(2) the attached decision is hereby deemed adopted by operation of law on October 24, 2012.

Pursuant to Government Code section 11519, this Decision shall become effective on November 23, 2012.

Date: October 24, 2012.

Louise R. Bailey M.Ed, RN

Louise R. Bailey, M.Ed., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 2012-345
EUGENIO LIMBAGO BAQUIAL	OAH No. 2012020985
Registered Nurse License No. 722918	
Respondent.	

PROPOSED DECISION

On June 29, 2012, in San Diego, California, Alan S. Meth, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter.

Michael German, Deputy Attorney General, Office of the Attorney General, represented complainant.

Respondent represented himself.

The matter was submitted on June 29, 2012.

FACTUAL FINDINGS

1. On December 6, 2011, Louise R. Bailey, M.Ed., R.N., Executive Officer, Board of Registered Nursing of the State of California (Board), filed Accusation No. 2012-345 in her official capacity. Respondent filed a timely Notice of Defense.

2. On March 17, 2008, the Board issued registered nurse license number 722918 to respondent and at all relevant times, the license was in full force and effect.

3. In approximately September 2009, respondent began working as a registered nurse in the intensive care unit Scripps Mercy Hospital (Scripps) in Chula Vista, California. By letter dated November 12, 2010, Scripps terminated respondent's employment at the hospital.

4. Michelle Tsugawa is a licensed pharmacist and is the Director of Pharmacy at Scripps. As part of her duties, she does routine reviews of the dispensing records from the numerous Pyxis cabinets used at the hospital. Pyxis the a trade name for an automatic,

computer-controlled single-unit dose medication dispensing system that records information such as patient name, physician orders, the date and time the medication is withdrawn, and the name of the licensed person who withdraws the medication. Each operator is given a user identification code and must login using a password. The system also requires the user's fingerprint. There are three Pyxis cabinets in the ICU.

During a routine review of the Pyxis records in the ICU in October 2010, Ms. Tsugawa found unusual activity regarding respondent's withdrawal of hydromorphone, known by the brand name Dilaudid, a Schedule II controlled substance. Her review revealed respondent made 52 withdrawals of Dilaudid for 19 patients during the month, compared to eight removals for three patients for the next most frequent user. She determined this was a significant difference. Ms. Tsugawa then looked at the individual transactions for each removal and examined the patient records.

Terry Taylor is the supervising registered nurse of the ICU at Scripps and is respondent's supervisor. Ms. Tsugawa showed her the information she had obtained regarding respondent's removal of Dilaudid during the month of October 2010. They found that there were numerous removals that were not documented and a high number of wastage transactions or inappropriate wastage, and some of the removals were for patients who had not been assigned to respondent. They also found respondent removed Dilaudid more frequently than ordered by the patients' doctors.

Ms. Taylor reviewed the relevant medical records, including the patient orders, flowsheets, medication administration record (MAR), Pyxis withdrawal records, etc., relating to respondent's withdrawals, and concluded the picture "showed a mess." She found a lot of wastage and no documentation that patients received any medications. With all the information available, she created a spreadsheet that tracked all the records.

The review disclosed that respondent was responsible for the removal of 33 mg of hydromorphone which were not accounted for.

Sussie Pangcog is the Director of Patient Care at Scripps. Ms. Taylor and Ms. Tsugawa, following Scripps protocols, took the information they had developed to Ms. Pangcog. She reviewed the records and contacted Karen Wolmer in the human resources department.

By letter dated November 8, 2010 to respondent, Ms. Taylor confirmed that Scripps had placed respondent on investigatory leave pending an investigation surrounding the medication discrepancies revealed by the review.

On November 10, 2010, respondent attended a meeting with Ms. Taylor, Ms. Pangcog, and Ms. Wolmer. As Ms. Taylor explained their findings, respondent stopped her before she finished and said he had taken the Dilaudid medications from Pyxis without authorization in violation of the hospital rules and protocols, and that he had a drug problem. Scripps terminated his employment two days later.

5. The accusation alleges that there were discrepancies in the records of six patients which were reviewed by Scripps staff during September and October 2010. Based upon their testimony, the documentary evidence, and respondent's admission to Scripps staff, and his admission at the hearing that the charges in the accusation were true and correct, the following was established:

a. Patient No. 1: This patient had a physician's order for .25 mg hydromorphone IV every four hours as needed for pain. Respondent was not assigned to this patient. Respondent failed to account for a minimum of 4.25 mg of hydromorphone withdrawn for this patient as follows:

i. At 0124 hours on October 16, 2010, respondent removed 2 mg hydromorphone from Pyxis and immediately logged 1.75 mg wasted. Respondent did not conduct an assessment of the patient, or chart the administration of the medication in the patient's MAR. Respondent failed to account for .25 mg of hydromorphone.

ii. At 1929 hours that day, respondent removed 2 mg hydromorphone from Pyxis. Respondent did not conduct an assessment of the patient, did not chart the administration of the medication in the patient's MAR, and there was no wastage. Respondent failed to account for 2 mg of hydromorphone.

iii. At 0333 on October 17, respondent removed 2 mg from Pyxis but did not conduct an assessment of the patient, did not chart the administration of the medication in the patient's MAR, and there was no wastage recorded. Respondent failed to account for 2 mg of hydromorphone.

b. Patient No. 2: This patient had a physician's order for 2 mg hydromorphone IV every four hours as needed for pain. Respondent was not assigned to this patient. At 2128 on September 24, 2010, respondent removed 2 mg hydromorphone from Pyxis. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage. Respondent failed to account for 2 mg of hydromorphone.

c. Patient No. 3: This patient had a physician's order for .5 hydromorphone IV every three hours as needed for pain. Respondent failed to account for a minimum of 4.5 mg hydromorphone withdrawn for this patient as follows:

i. At 1920 on October 17, respondent removed 2 mg hydromorphone from Pyxis and immediately logged 1.5 mg wasted. Another .5 mg was logged wasted at 1943. Respondent charted the administration of .5 mg hydromorphone in the patient's MAR at 2000, however, the amount was inconsistent with the recorded wastage.

ii. At 1944 the same day, 24 minutes after the last Pyxis withdrawal, respondent removed an additional 2 mg hydromorphone and immediately logged 1.5 mg wasted. Respondent did not chart the administration of the hydromorphone dose in the patient's MAR. Respondent failed to account for .5 mg of hydromorphone.

iii. At 2225 on October 17, respondent removed 2 mg hydromorphone from Pyxis, and recorded 1.5 mg wasted. The entry in the patient's MAR was unreadable.

iv. At 0112 on October 18, respondent removed 2 mg hydromorphone from Pyxis and recorded 1.5 mg wasted. Respondent charted 1.5 mg administered at 0130 in the patient's MAR.

v. At 0430 on October 18, respondent removed 2 mg hydromorphone from Pyxis and recorded 1.5 mg wasted. The entry in the patient's chart was unreadable.

vi. At 2147 the same day, respondent removed 2 mg hydromorphone from Pyxis. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage recorded. Respondent failed to account for 2 mg of hydromorphone.

vii. At 0042 on October 19, 2010, respondent removed 2 mg hydromorphone from Pyxis and charted .5 mg administered in the patient's MAR at 0040. No wastage was recorded. Respondent failed to account for 1.5 mg of hydromorphone.

viii. At 0046 the same day, respondent removed 2 mg hydromorphone from Pyxis and charted 1.5 mg wasted. Respondent failed to chart the administration of the hydromorphone in the patient's MAR. Respondent failed to account for .5 mg of hydromorphone.

d. Patient. No 4: This patient had a physician's order for 2 mg hydromorphone IV every two hours as needed for pain. Respondent failed to account for a minimum of 10 mg of hydromorphone withdrawn for this patient as follows:

i. At 0116 on October 10, respondent removed 2 mg hydromorphone from Pyxis. The patient received no hydromorphone on the previous shift. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage. Respondent failed to account for 2 mg of hydromorphone.

ii. At 0332 on October 10, respondent removed 2 mg of hydromorphone from Pyxis. The patient received no hydromorphone on the previous shift. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage. Respondent failed to account for 2 mg of hydromorphone.

iii. At 0552 on October 10, respondent removed 2 mg of hydromorphone from Pyxis. The patient received no hydromorphone on the previous shift. Respondent did not conduct an assessment of the patient, did not chart the administration of

the hydromorphone in the patient's MAR, and there was no wastage. Respondent failed to account for 2 mg of hydromorphone.

iv. At 2002 on October 10, respondent removed 2 mg of hydromorphone from Pyxis. The patient received no hydromorphone on the previous shift. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage. Respondent failed to account for 2 mg of hydromorphone.

v. At 2246 on October 10, respondent removed 2 mg of hydromorphone from Pyxis. The patient received no hydromorphone on the previous shift. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage. Respondent failed to account for 2 mg of hydromorphone.

vi. At 0155 on October 11, respondent removed 2 mg of hydromorphone from Pyxis and charted it administered at 0200 in the patient's MAR. The patient received no hydromorphone on the previous shift. Respondent did not conduct an assessment of the patient.

vii. At 0417 on October 11, respondent removed 2 mg of hydromorphone from Pyxis and charted it administered at 0400 in the patient's MAR. The patient received no hydromorphone on the previous shift. Respondent conduct a partial assessment of the patient.

viii. At 0612 on October 11, respondent removed 2 mg of hydromorphone from Pyxis and charted it administered at 0600 in the patient's MAR. The patient received no hydromorphone on the previous shift. Respondent conduct a partial assessment of the patient.

e. Patient No. 5: This patient had a physician's order for .25 mg hydromorphone IV every two hours as needed for pain. Respondent failed to account for a minimum of 6.25 mg of hydromorphone withdrawn for this patient as follows:

i. At 2234 on October 30, respondent removed 2 mg of hydromorphone from Pyxis and immediately recorded 1.5 mg wasted. Respondent did not conduct an assessment of the patient or chart the administration of the hydromorphone in the patient's MAR. Respondent failed to account for .25 mg of hydromorphone.

ii. At 0617 on October 30, respondent removed 2 mg of hydromorphone from Pyxis and immediately recorded 1.5 mg wasted. Respondent conducted a partial assessment of the patient and did not chart the administration of the hydromorphone in the patient's MAR. Respondent failed to account for .25 mg of hydromorphone.

iii. At 1923 on October 30, respondent removed 2 mg of hydromorphone from Pyxis. Respondent charted the administration of .25 mg hydromorphone in the patient's MAR. No wastage was recorded. Respondent failed to account for 1.75 mg of hydromorphone.

iv. At 2121 on October 10, respondent removed 2 mg of hydromorphone from Pyxis. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage. Respondent failed to account for 2 mg of hydromorphone.

v. At 2345 on October 10, respondent removed 2 mg of hydromorphone from Pyxis. Respondent conducted a partial assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage. Respondent failed to account for 2 mg of hydromorphone.

f. Patient No. 6: This patient had a physician's order for .25 mg hydromorphone IV every two hours as needed for pain. Respondent failed to account for a minimum of .4 mg of hydromorphone withdrawn for this patient as follows:

i. At 2010 on October 8, respondent removed 2 mg of hydromorphone from Pyxis and immediately recorded 1.5 mg wasted. Respondent did not chart the administration of the hydromorphone in the patient's MAR. Respondent failed to account for .2 mg of hydromorphone.

ii. At 2140 on October 8, respondent removed 2 mg of hydromorphone from Pyxis and immediately recorded 1.8 mg wasted. Respondent did not chart the administration of the hydromorphone in the patient's MAR. Respondent failed to account for .2 mg of hydromorphone.

6. In addition to the 52 removals Ms. Tsugawa discovered for October 2010 which she considered excessively high, her review of removals of hydromorphone from May to September 2010 revealed that respondent's removals were considerably higher than the removals of other users.

7. On November 20, 2008, in the Orange County Superior Court, respondent pleaded guilty and was convicted of one count of violating Vehicle Code section 23103, subdivision (a) pursuant to Vehicle Code section 23103.5, reckless driving in place of a charge of driving under the influence of alcohol, a misdemeanor. The court placed respondent on probation for three years on condition, among others, he pay fines and fees in excess of $300.00, and attend and complete a 12-hr Alcohol and Drug Program.

The facts and circumstances of the offense according to the police report are as follows: On May 13, 2008, a Huntington Beach Police Department officer observed respondent driving, and saw repeatedly cross over the center divider, stop at a red light in the middle of the intersection, and fail to drive when the light turned green for approximately five seconds. The officer conducted a traffic stop. Respondent told the officer he should not

have been driving and had had too much to drink. The officer smelled the odor of an alcoholic beverage on respondent's breath and noticed his eyes were watery and bloodshot. When respondent exited the car, his gait was unsteady. The officer had respondent perform a series of field sobriety tests, and then concluded respondent was under the influence of alcohol and arrested him for driving under the influence of alcohol. Respondent submitted to a blood test but the record does not indicate respondent's blood alcohol level.

8. Respondent testified at the hearing and admitted responsibility for the 33 mg of unaccounted-for hydromorphone and admitted that he failed to properly assess patients and follow Scripps policies and procedures. He apologized for his conduct and expressed relief that he was caught before he could harm any patient.

Respondent testified that he asked for help from Scripps and was referred to the Employee Assistance Program which referred him to Dr. Paul Strauss. Dr. Strauss diagnosed him with depression. As a result of this, respondent began attending 12-step meetings.

During the course of these proceedings, respondent was offered the opportunity to participate in the nurse diversion program, but he testified he declined and instead moved to his home in Little Rock, Arkansas. While there, he began seeing a psychiatrist who also advised respondent to participate in 12-step meetings. Respondent testified the physician administered a drug screen and the results were clean.

In April 2011, respondent contacted the Arkansas Board of Nursing hoping that he could practice there, but was told he needed an evaluation. The psychiatrist provided one but he was then told that he could not work in Arkansas until the investigation in California concluded. In October 2011, respondent went to New York where he worked as a courier, but after a month, he returned to Little Rock and obtained a job as a driver for Pizza Hut, where he is still employed.

Respondent testified he believes he is a good nurse, and pointed to several employee evaluations that showed this. He testified he has worked in several hospitals in several states over the years. He testified he misses nursing and wants to contribute to the profession.

Regarding his reckless driving conviction, respondent testified he was not found to be over the legal limit, he paid his fine and attended the driving course, and his driver's license is in good standing.

9. The Board incurred costs of investigation and enforcement of this matter for the services of the Attorney General in the amount of $7,947.50 and the services of the Division of Investigation in the amount of $7,084.00. The total is $15,031.50. The amount is reasonable.

LEGAL CONCLUSIONS

1. Business and Professions Code section 490 provides in part:

"A board may suspend or revoke a license on the ground that the licensee has been convicted of a crime, if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued. A conviction within the meaning of this section means a plea or verdict of guilty or a conviction following a plea of nolo contendere . . . ."

2. Business and Professions Code section 2761 provides in part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

[¶] . . .

(f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof."

3. Business and Professions Code section 2762 provides in part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a)

and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof.

(d) Be committed or confined by a court of competent jurisdiction for intemperate use of or addiction to the use of any of the substances described in subdivisions (a) and (b) of this section, in which event the court order of commitment or confinement is prima facie evidence of such commitment or confinement.

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

4. Title 16, California Code of Regulations, section 1443 provides:

"As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

5. Title 16, California Code of Regulations, section 1444 provides:

"A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such convictions or acts shall include but not be limited to the following:

(a) Assaultive or abusive conduct including, but not limited to, those violations listed in subdivision (d) of Penal Code Section 11160.

(b) Failure to comply with any mandatory reporting requirements.

(c) Theft, dishonesty, fraud, or deceit.

(d) Any conviction or act subject to an order of registration pursuant to Section 290 of the Penal Code."

6. Title 16, California Code of Regulations, section 1444.5 provides:

"In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.), the Board shall consider the disciplinary guidelines entitled: "Recommended Guidelines for Disciplinary Orders and Conditions of Probation" (10/02) which are hereby incorporated by reference. Deviation from these guidelines and orders, including the standard terms of probation,

is appropriate where the board in its sole discretion determines that the facts of the particular case warrant such a deviation -for example: the presence of mitigating factors; the age of the case; evidentiary problems."

7. The purpose of an administrative proceeding seeking the revocation or suspension of a professional license is not to punish the individual; the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners. (*Ettinger v. Board* of Medical Quality Assurance (1982) 135 Cal.App.3d 853, 856.)

The standard of proof in an administrative disciplinary proceeding seeking to suspend or revoke a professional license is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance*, *supra*, at 856.) Guilt must be established to a reasonable certainty and it cannot be based on surmise or conjecture, suspicion or theoretical conclusions, or uncorroborated hearsay. (*Pettit v. State Board of Education* (1973) 10 Cal.3d 29, 37.) The obligation to establish charges by clear and convincing evidence is a heavy burden. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

The conclusion that a licensee's conviction justifies discipline requires a reasoned determination that the conduct was in fact substantially related to the licensee's fitness to engage in the profession. Licensing authorities do not have unfettered discretion to determine whether a given conviction is substantially related to the relevant professional qualifications. Licensing authorities are required to develop criteria to aid them in making that determination. (*Robbins v. Davi* (2009) 175 Cal.App.4th 118, 124.)

8. Cause to suspend or revoke respondent's registered nurse license pursuant to Business and Professions Code section 2761, subdivision (a), incompetence, was established by Findings 4 and 5.

9. Cause to suspend or revoke respondent's registered nurse license pursuant to Business and Professions Code section 2762, subdivision (a), unlawful possession of controlled substances, was established by Findings 4 and 5.

10. Cause to suspend or revoke respondent's registered nurse license pursuant to Business and Professions Code section 2762, subdivision (f), falsifying or making grossly incorrect, inconsistent, or unintelligible entries in hospital and patient records pertaining to controlled substances, was established by Findings 4 and 5.

11. In this case, respondent was charged with having been convicted of one offense commonly referred to as a wet reckless under circumstances in which there was no injury to any person and the offense was committed at a time wholly unrelated to his practice of nursing. No appellate case has been found for which license discipline has been imposed for the conviction of a single wet reckless offense. *Compare Griffiths v. Superior Court*

(2002) 96 Cal.App.4th 757,

California Code of Regulations, title 16, section 1444 provides that a crime or act is substantially related to the qualifications, functions or duties of a person holding a license under the Nursing Practice Act if to a substantial degree the crime or act evidences the present or potential unfitness of the licensee to perform the functions authorized by the license in a manner consistent with the public health, safety, or welfare. The regulation focuses on crimes or acts involving a violation or an attempted violation of the Nursing Practice Act or the conviction of a crime involving assaultive or abusive conduct, failure to comply with mandatory reporting requirements, fiscal dishonesty, or sex offenses, although it is not limited specifically to those crimes and acts. A wet reckless conviction does not violate directly the Nursing Practice Act and is not one of the enumerated offenses. It may evidence a potential unfitness to practice, depending upon the circumstances. In attorney discipline cases, the suitability of an attorney to practice law is called into question where the incident is compounded by serious injury or death or is coupled with other aggravating behavior. (*Matter of Respondent I* (1993) 2 Cal. State Bar Ct. Rptr. 260, 270.) There are no such circumstances in this case.

12. Cause to suspend or revoke respondent's registered nurse license pursuant to Business and Professions Code sections 490, 2761, subdivision (f), and 2762, subdivision (c), conviction of a crime substantially related to the qualifications, functions, and duties of a registered nurse, was not established. The clear and convincing evidence did not establish that respondent's sole conviction met the criteria set forth in Title 16, California Code of Regulations, section 1444 or otherwise establish that respondent is unfit to practice nursing, or that the conviction was substantially related to the qualifications, functions, and duties of a registered nurse.

13. Cause to suspend or revoke respondent's registered nurse license pursuant to Business and Professions Code section 2762, subdivision (b), use of alcoholic beverages to an extent or in a manner dangerous to himself or others, was established by Finding 7. The clear and convincing evidence established that respondent drove in a reckless manner after consuming alcohol, and that his consumption of alcohol was to the extent and in such a manner as to be dangerous to himself and others.

14. Cause to suspend or revoke respondent's registered nurse license pursuant to Business and Professions Code section 2762, subdivision (c), conviction of an alcohol-related criminal offense, was established by Finding 7.

15. Title 16, California Code of Regulations, section 1444.5 provides:

"In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.), the Board shall consider the disciplinary guidelines entitled: "Recommended Guidelines for Disciplinary Orders and Conditions of Probation" (10/02) which are hereby incorporated by reference. Deviation from these guidelines and orders, including the standard terms of probation,

is appropriate where the board in its sole discretion determines that the facts of the particular case warrant such a deviation -for example: the presence of mitigating factors; the age of the case; evidentiary problems."

16. The Board's Disciplinary Guidelines provide in part:

"In determining whether revocation, suspension or probation is to be imposed in a given case, factors such as the following should be considered:

1. Nature and severity of the act(s), offenses, or crime(s) under consideration.

2. Actual or potential harm to the public.

3. Actual or potential harm to any patient.

4. Prior disciplinary record.

5. Number and/or variety of current violations.

6. Mitigation evidence.

7. Rehabilitation evidence.

8. In case of a criminal conviction, compliance with conditions of sentence and/or court-ordered probation.

9 Overall criminal record.

10. Time passed since the act(s) or offense(s) occurred.

11. If applicable, evidence of expungement proceedings pursuant to Penal Code Section 1203.4."

17. The evidence established that for several months, beginning shortly after he was hired by Scripps, respondent took advantage of his position as a registered nurse by withdrawing large amounts of dilaudid for his own use. His actions had the potential to cause harm to himself, his patients, and the public. Respondent offered no justification or excuse for his conduct, nor did he offer any evidence of mitigation. Respondent has been licensed as a registered nurse in California for four years, and this is the first disciplinary matter brought against his license.

As for rehabilitation, respondent testified he has received psychiatric counseling and has attended A.A. meetings but he offered no evidence to corroborate his testimony. Without substantial evidence to support the conclusion that respondent is addressing his drug addiction, allowing respondent to continue to practice nursing is unjustified and represents a

risk to the public. Under these circumstances, the only appropriate penalty is revocation of his license.

Respondent testified he was given the opportunity to enter the Board's drug diversion program, but chose not to do so. Had he chosen to enter the program, he could have continued to work as a registered nurse in this state and if successful, avoided a disciplinary proceeding. This is respondent's first offense and frequently in this type of case, such persons are placed on probation. Probation is not appropriate in this case because respondent presented no evidence beyond his own testimony that he is successfully addressing his drug problem.

Under Business and Professions Code section 2760.1, subdivision (a)(1), a nurse whose license is revoked must wait three years before he or she may apply reinstatement of the revoked license, but the Board has the discretion to reduce that time period. Because this is respondent's first offense, and he testified that he is addressing his drug problem, it would not be against the public interest to reduce the period he must wait before he can apply for reinstatement. At that time, respondent would have the opportunity to offer to the Board appropriate evidence of his rehabilitation efforts, evidence he did not produce in this proceeding. Accordingly, pursuant to section 2760.1, subdivision (a)(1), respondent may petition the Board for reinstatement of his revoked license no less than two years from the effective date of this decision.

18. The Board incurred costs in the amount of $15,031.50. Finding 9.

In *Zuckerman* v. *State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45, the Supreme Court rejected a constitutional challenge to a cost regulation similar to Business and Professions Code section 125.3. In so doing, however, the Court directed the administrative law judge and the agency to evaluate several factors to ensure the cost provision did not deter individuals from exercising their right to a hearing: An agency must not assess the full costs where it would unfairly penalize the respondent who has committed some misconduct but who has used the hearing process to obtain the dismissal of some charges or a reduction in the severity of the penalty; the agency must consider a respondent's subjective good faith belief in the merits of his or her position and whether the respondent has raised a colorable challenge; the agency must consider a respondent's ability to pay; and the agency may not assess disproportionately large investigation and prosecution costs when it has conducted a disproportionately large investigation to prove that a respondent engaged in relatively innocuous misconduct.

In this proceeding, respondent since losing his job at Scripps worked for a short period of time as a courier in New York, and is now a driver for Pizza Hut in Little Rock, Arkansas and living at home. It is obvious respondent cannot pay these costs and under *Zuckerman*, the amount of the costs may be reduced. Accordingly, the Board's costs of its investigation and enforcement of this matter is reduced to $5000.00.

ORDER

1. Registered Nurse License No. 722918 issued to respondent Eugenio Limbago Baquial is revoked.

2. Respondent Eugenio Limbago Baquial may petition the Board for reinstatement of his revoked license no less than two years from the effective date of this decision.

3. Respondent Eugenio Limbago Baquial is hereby directed to pay to the Board of Registered Nursing the amount of $5,000.00 for its costs of investigation and enforcement. Payment shall become due within 60 days of the effective date of the Board's Decision in this matter.

DATED: July 2, 2012

ALAN S. METH
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **EUGENIO LIMBAGO BAQUIAL** **1205 Glenda Drive** **Littlerock, AR 72205** **Registered Nurse License No. 722918** Respondent.	Case No. 2012- 345 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about March 17, 2008, the Board of Registered Nursing issued Registered Nurse License Number 722918 to Eugenio Limbago Baquial (Respondent). The Registered Nurse License expired on September 30, 2011, and has not been renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 482 of the Code states:

> Each board under the provisions of this code shall develop criteria to evaluate the rehabilitation of a person when:
>
> (a) Considering the denial of a license by the board under Section 480; or
>
> (b) Considering suspension or revocation of a license under Section 490.
>
> Each board shall take into account all competent evidence of rehabilitation furnished by the applicant or licensee.

7. Section 490 of the Code provides, in pertinent part, that a board may suspend or revoke a license on the ground that the licensee has been convicted of a crime substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued.

8. Section 493 of the Code states:

> Notwithstanding any other provision of law, in a proceeding conducted by a board within the department pursuant to law to deny an application for a license or to suspend or revoke a license or otherwise take disciplinary action against a person who holds a license, upon the ground that the applicant or the licensee has been convicted of a crime substantially related to the qualifications, functions, and duties of the licensee in question, the record of conviction of the crime shall be conclusive evidence of the fact that the conviction occurred, but only of that fact, and the board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, and duties of the licensee in question.
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> As used in this section, "license" includes "certificate," "permit," "authority," and "registration."

9. Section 2761 of the Code states:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . . .

(f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof.

. . . .

10. Section 2762 of the Code states:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof.

. . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

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11. Section 2765 of the Code states:

A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions and duties of a registered nurse is deemed to be a conviction within the meaning of this article. The board may order the license or certificate suspended or revoked, or may decline to issue a license or certificate, when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information or indictment.

REGULATORY PROVISIONS

12. California Code of Regulations, title 16, section 1443, states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

13. California Code of Regulations, title 16, section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

14. California Code of Regulations, title 16, section 1444, states:

A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such convictions or acts shall include but not be limited to the following:

(a) Assaultive or abusive conduct including, but not limited to, those violations listed in subdivision (d) of Penal Code Section 11160.

(b) Failure to comply with any mandatory reporting requirements.

(c) Theft, dishonesty, fraud, or deceit.

(d) Any conviction or act subject to an order of registration pursuant to Section 290 of the Penal Code.

15. California Code of Regulations, title 16, section 1445 states:

. . . .

(b) When considering the suspension or revocation of a license on the grounds that a registered nurse has been convicted of a crime, the board, in evaluating the rehabilitation of such person and his/her eligibility for a license will consider the following criteria:

(1) Nature and severity of the act(s) or offense(s).

(2) Total criminal record.

(3) The time that has elapsed since commission of the act(s) or offense(s).

(4) Whether the licensee has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against the licensee.

(5) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.

(6) Evidence, if any, of rehabilitation submitted by the licensee.

COSTS

16. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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DRUG

17. Hydromorphone, known by the brand name Dilaudid, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, subdivision (b)(1)(K), and is a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

18. Respondent began employment as a registered nurse with Scripps Mercy Hospital (SMH) in Chula Vista on September 30, 2009. As part of his new hire orientation, Respondent signed SMH's "Drug-Free Workplace Policy Statement" agreeing that he would comply with its provisions. Respondent was also responsible for knowing and abiding by SMH policies and procedures, including "Medications: Orders, Administration, and Documentation," and "Pain Management." At the time of the incidents described herein, Respondent was assigned to SMH's Intensive Care Unit (ICU).

19. On or about November 10, 2010, the SMH Pharmacy Director conducted a routine diversion audit. The audit revealed that for the month of October 2010, Respondent removed 52 doses of Dilaudid for 19 patients from the Pyxis Medstations[1] in the ICU, compared to eight doses for four patients by the next highest coworker.

20. The Pharmacy Director reported her findings to the ICU Manager. Together they conducted a review of hospital records which revealed that Respondent had been removing narcotics from Pyxis for patients that were not assigned to him, he was removing narcotics more frequently than ordered by the physician, and he exhibited a pattern of withdrawing and immediately wasting narcotics. Their investigation revealed the following discrepancies in the records of six patients that were selected for review:

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[1] "Pyxis" is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, the date and time the medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. Sometimes only portions of the withdrawn medications are administered to the patient. The portions not administered are referred to as "wastage." Wasted medications must be disposed of in accordance with hospital rules and must be witnessed by another authorized user and recorded in Pyxis.

21. Patient No. 1: This patient had a physician's order for .25 mg hydromorphone IV every four hours as needed for pain. Respondent was not assigned to this patient. Respondent failed to account for a minimum of 4.25 mg of hydromorphone withdrawn for this patient as follows:

a. At 0124 hours on October 16, 2010, Respondent removed 2 mg hydromorphone from Pyxis and immediately logged 1.75 mg wasted. Respondent did not conduct an assessment of the patient, or chart the administration of the hydromorphone in the patient's Medication Administration Record (MAR). Respondent failed to account for .25 mg of hydromorphone.

b. At 1929 on October 16, 2010, Respondent removed 2 mg hydromorphone from Pyxis. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage recorded. Respondent failed to account for 2 mg of hydromorphone.

c. At 0333 on October 17, 2010, Respondent removed 2 mg hydromorphone from Pyxis. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage recorded. Respondent failed to account for 2 mg of hydromorphone.

22. Patient No. 2: This patient had a physician's order for 2 mg hydromorphone IV every four hours as needed for pain. Respondent was not assigned to this patient. At 2128 on September 24, 2010, Respondent removed 2 mg hydromorphone from Pyxis. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage recorded. Respondent failed to account for 2 mg of hydromorphone.

23. Patient No. 3: This patient had a physician's order for .5 mg hydromorphone IV every three hours as needed for pain. Respondent failed to account for a minimum of 4.5 mg hydromorphone withdrawn for this patient as follows:

a. At 1920 on October 17, 2010, Respondent removed 2 mg hydromorphone from Pyxis and immediately logged 1.5 mg wasted. Another .5 mg was logged wasted at 1943.

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Respondent charted the administration of .5 mg the hydromorphone in the patient's MAR at 2000, however the amount was inconsistent with the recorded wastage.

b. At 1944 on October 17, 2010, 24 minutes after the last Pyxis withdrawal, Respondent removed an additional 2 mg hydromorphone and immediately logged 1.5 mg wasted. Respondent did not chart the administration of the hydromorphone dose in the patient's MAR. Respondent failed to account for .5 mg of hydromorphone.

c. At 2225 on October 17, 2010, Respondent removed 2 mg hydromorphone from Pyxis, and recorded 1.5 mg wasted. The entry in the patient's MAR was unreadable.

d. At 0112 on October 18, 2010, Respondent removed 2 mg hydromorphone from Pyxis and recorded 1.5 mg wasted. Respondent charted 1.5 mg administered at 0130 in the patient's MAR.

e. At 0430 on October 18, 2010, Respondent removed 2 mg hydromorphone from Pyxis, and recorded 1.5 mg wasted. The entry in the patient's MAR was unreadable.

f. At 2147 on October 18, 2010, Respondent removed 2 mg hydromorphone from Pyxis. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage recorded. Respondent failed to account for 2 mg of hydromorphone.

g. At 0042 on October 19, 2010, Respondent removed 2 mg hydromorphone from Pyxis and charted .5 mg administered in the patient's MAR at 0040. No wastage was recorded. Respondent failed to account for 1.5 mg of hydromorphone.

h. At 0046 on October 19, 2010, Respondent removed 2 mg hydromorphone from Pyxis and charted 1.5 mg wasted. Respondent failed to chart the administration of the hydromorphone in the patient's MAR. Respondent failed to account for .5 mg of hydromorphone.

24. Patient No. 4: This patient had a physician's order for 2 mg hydromorphone IV every two hours as needed for pain. Respondent failed to account for a minimum of 10 mg of hydromorphone withdrawn for this patient as follows:

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a. At 0116 on October 10, 2010, Respondent removed 2 mg hydromorphone from Pyxis. This patient received no hydromorphone on the previous shift. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage recorded. Respondent failed to account for 2 mg of hydromorphone.

b. At 0332 on October 10, 2010, Respondent removed 2 mg hydromorphone from Pyxis. This patient received no hydromorphone on the previous shift. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage recorded. Respondent failed to account for 2 mg of hydromorphone.

c. At 0552 on October 10, 2010, Respondent removed 2 mg hydromorphone from Pyxis. This patient received no hydromorphone on the previous shift. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage recorded. Respondent failed to account for 2 mg of hydromorphone.

d. At 2002 on October 10, 2010, Respondent removed 2 mg hydromorphone from Pyxis. This patient received no hydromorphone on the previous shift, and the patient denied having pain. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage recorded. Respondent failed to account for 2 mg of hydromorphone.

e. At 2246 on October 10, 2010, Respondent removed 2 mg hydromorphone from Pyxis. This patient received no hydromorphone on the previous shift. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage recorded. Respondent failed to account for 2 mg of hydromorphone.

f. At 0155 on October 11, 2010, Respondent removed 2 mg hydromorphone from Pyxis and charted it administered at 0200 in the patient's MAR. This patient received no hydromorphone on the previous shift. Respondent did not conduct an assessment of the patient.

g. At 0417 on October 11, 2010, Respondent removed 2 mg hydromorphone from Pyxis and charted it administered at 0400 in the patient's MAR. This patient received no hydromorphone on the previous shift. Respondent conducted a partial assessment of the patient.

h. At 0612 on October 11, 2010, Respondent removed 2 mg hydromorphone from Pyxis and charted it administered at 0600 in the patient's MAR. This patient received no hydromorphone on the previous shift. Respondent conducted a partial assessment of the patient.

25. Patient No. 5: This patient had a physician's order for .25 mg hydromorphone IV every two hours as needed for pain. Respondent failed to account for a minimum of 6.25 mg of hydromorphone withdrawn for this patient as follows:

a. At 0234 on October 30, 2010, Respondent removed 2mg hydromorphone from Pyxis and immediately recorded 1.5 mg wasted. Respondent did not conduct an assessment of the patient, or chart the administration of the hydromorphone in the patient's MAR. Respondent failed to account for .25 mg of hydromorphone.

b. At 0617 on October 30, 2010, Respondent removed 2mg hydromorphone from Pyxis and immediately recorded 1.5 mg wasted. Respondent conducted a partial assessment of the patient, and did not chart the administration of the hydromorphone in the patient's MAR. Respondent failed to account for .25 mg of hydromorphone.

c. At 1923 on October 30, 2010, Respondent removed 2mg hydromorphone from Pyxis. Respondent charted the administration of .25 mg hydromorphone in the patient's MAR. No wastage was recorded. Respondent failed to account for 1.75 mg of hydromorphone.

d. At 2121 on October 30, 2010, Respondent removed 2 mg hydromorphone from Pyxis. Respondent did not conduct an assessment of the patient, did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage recorded. Respondent failed to account for 2 mg of hydromorphone.

e. At 2345 on October 30, 2010, Respondent removed 2 mg hydromorphone from Pyxis. Respondent conducted a partial assessment of the patient. He did not chart the administration of the hydromorphone in the patient's MAR, and there was no wastage recorded. Respondent failed to account for 2 mg of hydromorphone.

26. Patient No. 6: This patient had a physician's order for .2 mg hydromorphone IV every two hours as needed for pain. Respondent failed to account for a minimum of .4 mg of hydromorphone withdrawn for this patient as follows:

a. At 2010 on October 8, 2010, Respondent removed 2 mg hydromorphone from Pyxis and immediately recorded 1.8 mg wasted. Respondent did not chart the administration of the hydromorphone in the patient's MAR. Respondent failed to account for .2 mg of hydromorphone.

b. At 2140 on October 8, 2010, Respondent removed 2 mg hydromorphone from Pyxis and immediately recorded 1.8 mg wasted. Respondent did not chart the administration of the hydromorphone in the patient's MAR. Respondent failed to account for .2 mg of hydromorphone.

27. On November 10, 2010, Respondent was summoned to a meeting with the SMH's Patient Care Director and the Senior Human resources Business Partner. Respondent admitted that he had been removing narcotics from Pyxis for his personal use. Respondent was immediately placed on administrative leave. Respondent's employment with SMH was terminated on November 12, 2010. SMH filed a complaint with the Board.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

28. Respondent has subjected his registered nurse license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that he was incompetent, as defined by California Code of Regulations, title 16, section 1442, in that during the period from September 24, 2010 to October 30, 2010, while employed as a registered nurse by SMH (as detailed in paragraphs 18-27, above), Respondent repeatedly removed hydromorphone from Pyxis and failed to properly document his handling of the narcotic in the hospital's MARs, medical records, or Pyxis. Respondent charted medications administered without conducting an assessment, he made illegible entries in patients' records, and he withdrew medications for patients who were not assigned to him. Respondent's actions demonstrated a repeated failure to

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exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Illegal Possession of Controlled Substances)

29. Respondent has subjected his registered nurse license to disciplinary action under section 2762, subdivision (a) of the Code for unprofessional conduct in that Respondent diverted and possessed controlled substances taken from his employers, as evidenced by his actions and admissions described in paragraphs 18-27.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Fraudulent Documentation in Hospital Records)

30. Respondent has subjected his registered nurse license to disciplinary action under section 2762, subdivision (e) of the Code for unprofessional conduct in that on multiple occasions, as described in paragraphs 18-27, above, Respondent intentionally falsified, or made grossly incorrect, inconsistent, or illegible entries in hospital, patient, and Pyxis records pertaining to controlled substances prescribed to patients.

FOURTH CAUSE FOR DISCIPLINE

(November 20, 2008 Criminal Conviction for Reckless Driving on May 13, 2008)

31. Respondent has subjected his license to disciplinary action under sections 490 and 2761, subdivision (f) of the Code in that Respondent was convicted of a crime that is substantially related to the qualifications, functions, and duties of a registered nurse. The circumstances are as follows:

a. On or about November 20, 2008, in a criminal proceeding entitled *People of the State of California v. Eugenio Limbago Baquial III,* in Orange County Superior Court, case number 08WM04124, Respondent was convicted on his plea of guilty of violating Vehicle Code section 23103, subdivision (a), alcohol-related reckless driving. Pursuant to Vehicle Code section 23103.5, said count was substituted for the original charge of violating Vehicle Code section 23152, subdivision (a), driving under the influence of alcohol.

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b. As a result of the conviction, on or about November 20, 2008, Respondent was sentenced to three years informal probation, and ordered to attend and complete a 12-hour Alcohol and Drug Program, pay fees, fines, and restitution in the amount of $534, and comply with the terms of probation.

c. The facts that led to the conviction are that in or about the early morning of May 13, 2008, a patrol officer with the Huntington Beach Police Department observed Respondent driving in an erratic manner characteristic of someone under the influence. The officer conducted a traffic stop. Upon contact with Respondent, Respondent admitted to the officer that he should not be driving and that he had too much to drink. While speaking with Respondent, the officer noted the odor of an alcoholic beverage on Respondent's breath, his eyes were bloodshot and watery, and a horizontal gaze nystagmus test was positive. When Respondent exited his vehicle, he was unsteady on his feet. Respondent submitted to a series of field sobriety tests which he was unable to complete satisfactorily. Respondent was arrested for driving under the influence of alcohol. During booking, Respondent complained that he was going to vomit, so he elected to provide a sample of blood for testing.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Use of Alcohol in a Dangerous Manner)

32. Respondent has subjected his registered nurse license to disciplinary action under section 2762, subdivision (b) of the Code for unprofessional conduct in that on or about May 13, 2008, as described in paragraph 31, above, Respondent used alcoholic beverages to an extent or in a manner that was potentially dangerous and injurious to himself, and to others in that he operated a motor vehicle while impaired by alcohol.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Conviction of an Alcohol-Related Criminal Offense)

33. Respondent has subjected his registered nurse license to disciplinary action under section 2762, subdivision (c) of the Code for unprofessional conduct in that on or about November 20, 2008, as described in paragraph 31, above, Respondent was convicted of a criminal offense involving the consumption and/or self-administration of alcohol.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 722918, issued to Eugenio Limbago Baquial;

2. Ordering Eugenio Limbago Baquial to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: December 6, 2011

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2011801536